Penny Joss Fletcher, M.A.

Licensed Marriage and Family Therapist
Individual and Marital Psychotherapy
Infertility and Adoption Counseling
515 E. First St., Suite D
Tustin, CA 92780
(714) 730-7996
www.infertility2adoption.com

Welcome to the office of Penny Joss Fletcher. In an attempt to establish a smoothly running office system and a professional relationship with my clients, I have developed the following policies and procedures. I ask that you read and sign this information sheet in order to ensure your understanding and willingness to abide by the policies as established. Please do not hesitate to ask questions, and thank you in advance for your cooperation.

1. It is my understanding that you have been referred to my office in preparation for a third party reproduction treatment cycle. We will meet for a psycho-educational counseling session to provide you with information about what to expect, and to confirm that you are ready and informed to continue with the cycle.

2. The session will take approximately 1 hour. I will then write a narrative report which will be sent to your physician. If I have any concerns about you proceeding with the treatment cycle, I will share them with you at the end of the session and with your physician in my report. I am not a gatekeeper and cannot cancel your cycle.

3. Payment is to be made at the time of the appointment. The fee for the counseling session and the report is $200.00. Insurance will not pay for this session and report.

4. Should you wish to enter into a therapeutic relationship with me, the following procedures would apply: Sessions are 50 minutes in length in order to allow me to complete paperwork, return phone calls, and effectively “switch gears” from one client to the next. Overtime or phone consultation time is billable in 15 minute intervals. I would appreciate it if you would fill out your check before the session begins, made payable to “Penny Joss Fletcher”, so as to maximize your valuable session time.

5. Payments are to be made at the time of each appointment which include insurance co-payments and unmet deductibles. The fee for Individual, Marital/Conjoint and Family Therapy is $100.00 per session. Please talk to me about your financial situation if necessary or if you wish to utilize insurance coverage.

6. In order to cancel or change an individual, marital, family or phone appointment, you must notify me at least 24 hours prior to the scheduled appointment. My voice mail handles calls 24 hours/day when I am not in the office. If proper notice is not received, you are responsible for payment for the missed session. Insurance cannot be billed for late cancellation or missed sessions.

I have read, understood, and agree to the above policies of Penny Joss Fletcher, M.A., MFT.

Signature____Date:_________________________

INTAKE FACE SHEET

The requested information becomes part of your file and is confidential. Please print.

Wife's Name ______________________________ Home Phone ( ) _________________________

Husband's Name ___________________________

Home Address ____

(number and street)

____

(city) (state) (zip code)

Wife's Date of Birth _______________________ Cell Phone ( ) _________________________

Email Address ____________________________

Husband's Date of Birth _______________________ Cell Phone ( ) _________________________

Email Address ____________________________

Wife Employed by ______________________________ Business Phone ( ) _____________________

May we call you at work? ___________________

Business Address ____

(number and street)

____

______ (city) (state) (zip code)

Wife's Social Security #: ___________________ Husband's Social Security # ______________________

Husband Employed by ___________________________ Business Phone ( ) _____________________

May we call you at work? ___________________

Business Address ____

(number and street)

____

______ (city) (state) (zip code)

Referred by: ____

In case of EMERGENCY contact:

Name: ____

Address: ____

(number and street) (city) (state) (zip)

Home Phone: ___________________________________ Business Phone: ___________________________

Date: ________________________

____________**CONFIDENTIAL BACKGROUND INFORMATION FORM - WIFE**

Please print.

Age_________ Educational Level____________________Occupation_________________________

Marital Status____Years Married_______________________

# of Pregnancies: _______ # of Children________ Names & Ages of Children ___________________

Previous counseling____
(name/names) (how long)

If you are currently under the care of a physician, please provide information:

Physician's Name: ____________________________ Physician's Telephone: ____________________

Date of last physical________________________Results____

Hospitalization____
(reason) (how long)

Medication____
(what kind/dosage/prescribed by)

____
(condition being treated by medication)

Current chronic conditions____

Family history of medical problems____

# of Siblings_______________ What sibling position are you?_______________________________

Parents: Are they still married, divorced, deceased?____

Is either parent remarried?____

Describe your mother____

____

Describe your father____

____

Persons living with client____

Relationship/marital history____

____

Raised in what religion: __________________________ Present religion:__________________________

__________CONFIDENTIAL BACKGROUND INFORMATION FORM - HUSBAND

Please print.

Age__________ Educational Level______________________Occupation____________________________

Marital Status____Years Married_________________________

# of Pregnancies: ________ # of Children_________ Names & Ages of Children _____________________

Previous counseling____
(name/names) (how long)

If you are currently under the care of a physician, please provide information:

Physician's Name: _______________________________ Physician's Telephone: _______________________

Date of last physical__________________________Results____

Hospitalization____
(reason) (how long)

Medication____
(what kind/dosage/prescribed by)

____
(condition being treated by medication)

Current chronic conditions____

Family history of medical problems____

# of Siblings_________________ What sibling position are you?____________________________________

Parents: Are they still married, divorced, deceased?____

Is either parent remarried?____

Describe your mother____

____

Describe your father____

____

Persons living with client____

Relationship/marital history____

____

Raised in what religion: _____________________________ Present religion:______________________________

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LIMITS OF CONFIDENTIALITY

The psychotherapeutic relationship and all client records are confidential. No client information will be given out without your written permission with the following exceptions:

- **ABUSE:** If you tell me that you have been mentally, physically or sexually abused as a minor, elder or a dependent adult, or if you indicate that you have in any way been involved in, or have knowledge of anyone being involved in any of the above referenced abuses to a minor, an elder or a dependent adult, I am required by California law to report this information to appropriate legal agencies.

- **THREAT OF HARM TO SELF OR ANOTHER:** Section 1024 of the Evidence Code of the State of California requires me to break confidentiality if I have reasonable cause to believe that a client is in such mental or emotional condition as to be dangerous to her/himself or to the person or property of another.

- **COURT ORDER:** Upon advise of counsel, I will comply with any lawful court order to release information about your contact here.

- **INSURANCE COMPANIES, EAP'S AND MANAGED CARE COMPANIES:** Most authorizing agents of your insurance benefits will require information such as diagnosis, treatment goals and plans, symptoms, mental health and chemical dependency history. This information does not go to your employer.

- **CONJOINT COUNSELING:** When working interchangeably with individual and conjoint sessions, information from individual sessions will not be given out in conjoint sessions.

I DECLARE THAT I HAVE READ AND UNDERSTAND THE ABOVE LIMITATIONS OF CONFIDENTIALITY AND AGREE TO ITS CONTENTS.

Signed:____ Dated:_____________________________________

Signed:____ Dated:_____________________________________

Witness:_______________________________________ Dated:_____________________________________